Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN TOMKO DC
3100 TIMMONS LANE #250
HOUSTON TX 77027

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0144-01

MFDR Date Received
SEPTEMBER 17, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have attached a copy of the original claim/bill and documentation as originally submitted, any copies of Explanation of Benefits/Reimbursement (EOB/EOR) submitted to our office pertaining to this claim, attachments showing proof of request of EOB/EOR that has not been received to date; as well as this letter of claim specifically explaining and outlining our position in accordance with TDI-DWC Rules and Regulations governing bills/claims submitted in reference to **DESIGNATED DOCTOR REFERRED DIAGNOSTIC TESTING**… Please note that the CPT codes and MAR as not bundled nor compounded and are to be billed and reimbursed separately and independently from one another. As you will note from the attached supporting documentation all components were performed and billed accordingly based on the TDI-DWC Fee Guidelines and per Rule 133. Please note that Designated Doctor Referred Diagnostic Testing is not subject to PPO or network reductions."

Amount in Dispute: $810.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2011	CPT Code 97750-FC	$810.40	$808.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §127.10 sets out the general procedures for Designated Doctor Examinations.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Workers' Compensation Specific Services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (96) – Non-covered charge(s).
   - 1 – The service(s) is for a condition(s) which is not related to the covered work related injury.
   - 1 – (214) – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
   - 1 – Service rendered does not relate to an accepted compensable injury or disease.

Issues

1. Was the testing part of a Designated Doctor Examination?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied the services using denial codes 1-(96) – "Non-covered charge(s); 1 – The service(s) is for a condition(s) which is not related to the covered work related injury; and 1-(214) – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment." The insurance carrier or its agent has not responded to the dispute, nor have they submitted any documentation to support their denials.

   Review of the documentation submitted by the requestor finds that the Function Capacity Evaluation (FCE) performed by Stephen Tomko, DC was referred by Designated Doctor, Julie C. Nguyen, MD. Furthermore, the Designated Doctor exam was Commissioner ordered and one of the purposes of the examination was to determine the extent of the employee's compensable injury. 28 Texas Administrative Code §127.10(c), states in pertinent part, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor may also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements or retrospective review requirements in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agent's Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively)..."
2. Review of the submitted documentation finds that the requestor performed the FCE at the referral of a Commissioner ordered Designated Doctor exam doctor; therefore, the reimbursement amount is as follows for CPT Code 97750, 16 units:
   - (54.54 ÷ 33.9764) x $31.46 = $50.51 x 16 units = $808.01

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $808.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $808.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 30, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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